Washington State Health Care Authority

WA State Health Information Management Association

Medicaid Program Integrity

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What we will cover . . .

Topics:

- **Program Integrity**: Fundamentals, Requirements, Landscape
- **The Office of Program Integrity**: Functions & Impact
- **Fraud**: Fundamentals and Examples
- **Common audit findings**
- **The Provider Appeal Process**
- **Preparing for an Audit/Review**
- **Emerging Medicaid Program Integrity Topics**

HCA Disclaimer

- This PowerPoint is for informational purposes only and the examples provided are for illustration only.
- Nothing herein is binding on the HCA, or exempts providers from their obligation to follow all applicable laws, rules, and guidelines.

Program Integrity Goals . . .

Program Integrity is an intentional and consistent set of controls designed to . . .

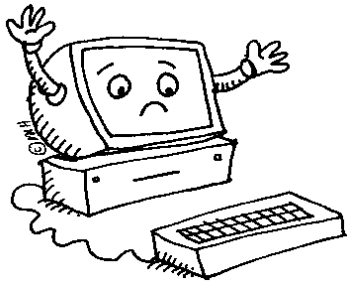
- Ensure the integrity of the Medicaid program in WA
- Maintain accountability and effective stewardship
- Safeguard and protect public funds
- Reduce and eliminate fraud, waste and abuse in the Medicaid program
- Promote provider awareness and responsibility

HCA and Medicaid providers share a joint responsibility and a common set of Program Integrity goals

Medicaid By the Numbers. . .

State Fiscal Year 2014 Medicaid . . .

- Each year Medicaid processes 3.9 billion claims - $430 billion paid for more than 57 million clients
- Medicaid currently serves ~1.7 million Washingtonians – 57% adults and 43% children
- ProviderOne Medicaid payment system paid over $8.5 billion in Calendar Year 2014
- XXX active providers; XXX billing providers
- Approximately 80% of WA Medicaid clients are served by contracted Managed Care Organizations



A careful balance . . .

Claims Receipt	Claims Input	Claims Adjudication	Post Pay Review
✓Provider Enrollment ✓Provider Credentialing	✓ Provider Verification ✓ Code Format checks ✓ Transaction segments ✓ Balancing ✓ Trading Partner test	✓ Edits/Audits ✓ Payment Logic ✓ Manual Review ✓ Predictive Models ✓ Investigations	✓ Pay and Chase" ✓ Algorithms ✓ Predictive Models ✓ Audits ✓ Investigations ✓ Provider Self-Review

HCA must carefully manage the balance between paying claims quickly and implementing review functions that detect fraud and abuse.

Why does HCA maintain a PI program?

The State of Washington requires Program Integrity:

A. 35 years ago the Legislature declared that it is "*in the public interest and for the protection of the health and welfare of the residents of the state of Washington that a proper regulatory and inspection program be instituted in connection with the providing of medical, dental, and other health services to recipients of public assistance.*" (***RCW 74.09.200***)

B. By this declaration, the people authorize and require the HCA "*to inspect and audit all records in connection with the providing of such services.*"

Why does HCA maintain a PI program?

Federal law mandates audits:

A. Participating state agencies are required to have an investigation and detection program for discovering, preventing, reducing, and otherwise dealing with fraud and abuse that result in unnecessary costs to the Medicaid program.

B. The State Medicaid Agency must:
   i. Identify and investigate cases
   ii. Respect legal rights and due process of law
   iii. Cooperate with federal and state legal authorities responsible for the prosecution of fraud.

Why does HCA maintain a PI program?

Federal laws have expanded expectations and requirements over the last 10 years.

A. The **Deficit Reduction Act of 2005** established the Medicaid Integrity Program, thereby authorizing Medicaid Integrity Contractors—like HMS—to audit state Medicaid providers.

B. The **Improper Payments Elimination and Recovery Act of 2010** expanded the use of recovery audits.

C. The **Affordable Care Act of 2010** provided another $350 million for federal program integrity efforts over the next 10 years.

Many state/federal auditors out there . . .

Public Money = Public Scrutiny

- At any time, a provider can be audited, investigated, or otherwise visited by any number of state and federal agencies.

- Though the provider may serve Medicaid clients, not every state or federal contact or visit is a "Medicaid Audit."

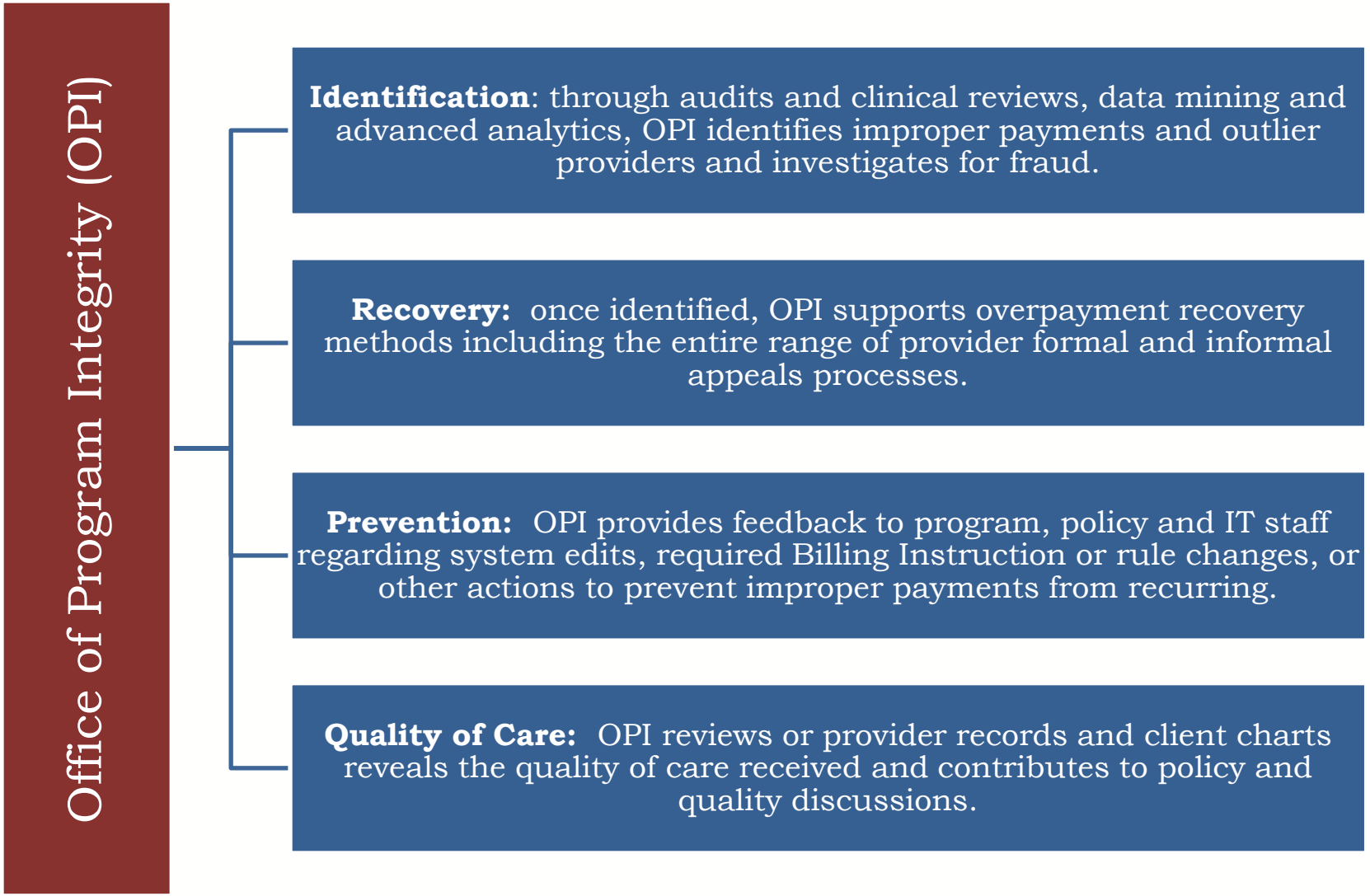
Others who may show up . . .

The State Auditor's Office, usually to examine providers to assess how HCA is managing a particular Medicaid program.

- **Labor & Industries** to assess quality of care
- **Department of Health** to review and/or suspend licenses.
- The **Department of Revenue** may want to audit a provider's taxes
- **Medicaid Fraud Control** may visit to investigate allegations received
- **Federal HHS/OIG** may request records to assess State management of the Medicaid dental program

The HCA neither authorizes nor controls these activities

The HCA Office of Program Integrity (OPI)



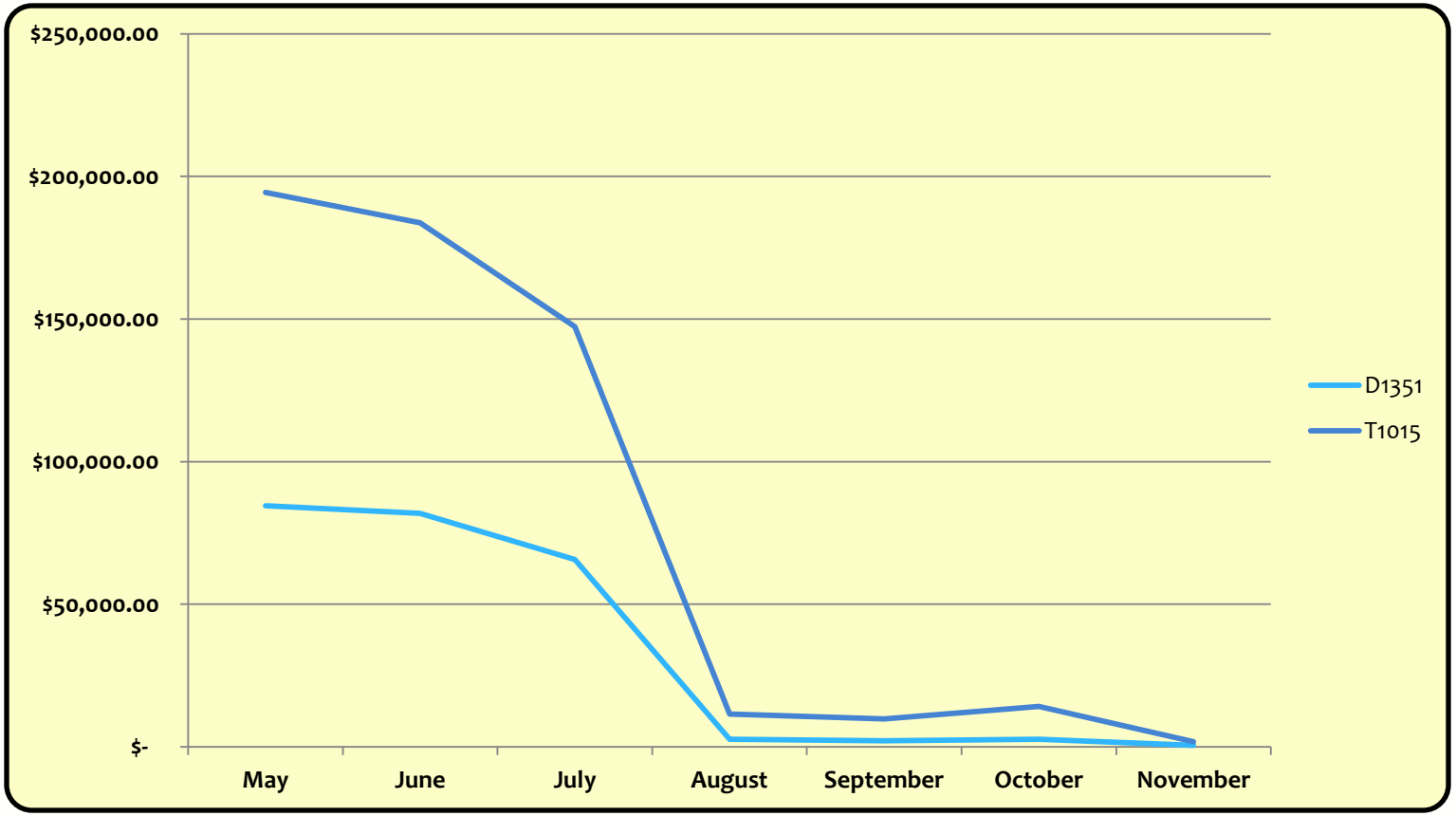
Office of Program Integrity

WA Program Integrity Activities

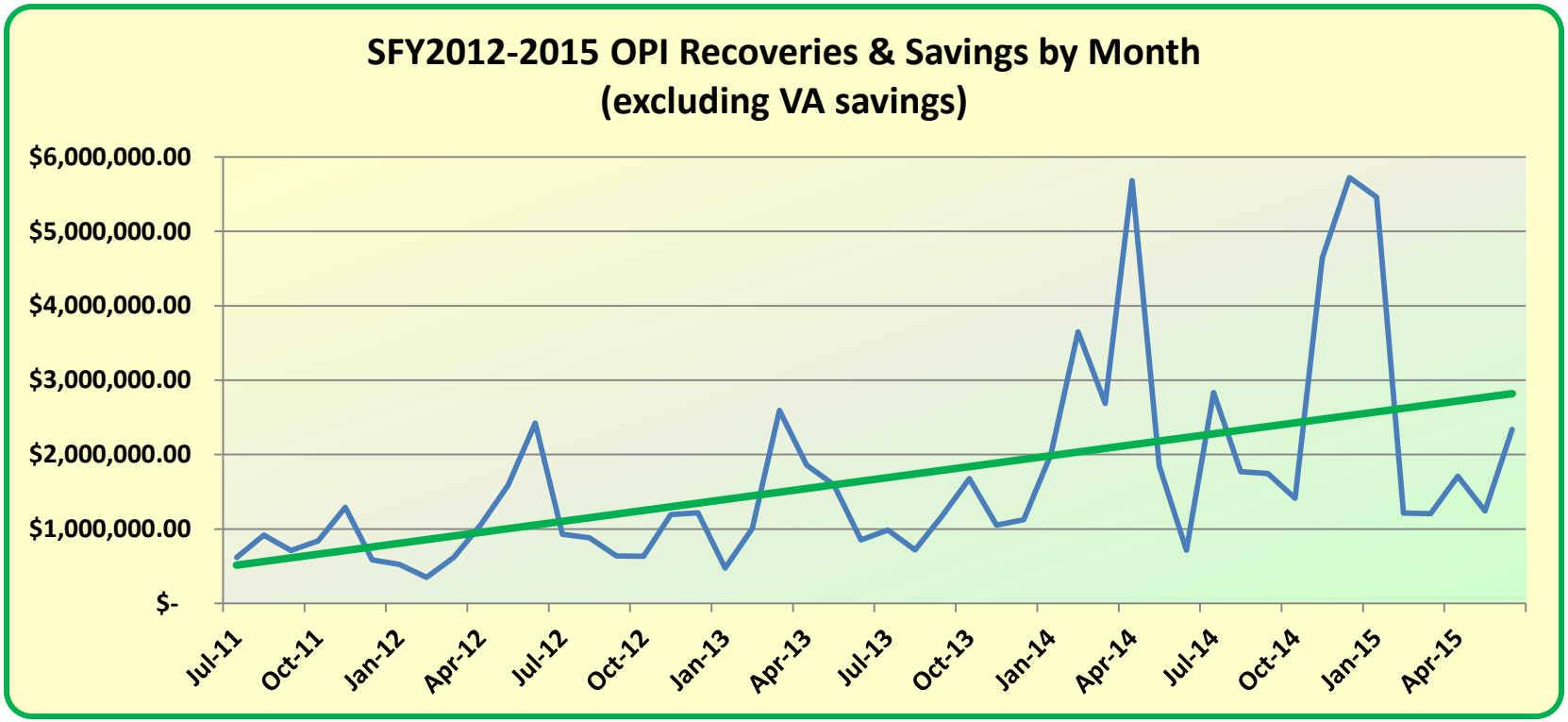
Who We Are & What We Do:

- Staff of 46
- Auditors, Analysts, Coders, Clinicians
- Activities:
  - Payment and Provider Audits & Reviews
  - Recovery Algorithms
  - Linking veterans to their federal benefits
  - ACA and other Federal Compliance Initiatives
  - Providing access to data
  - System-wide Policy & Technical QA
  - Manage relationships with other state and federal PI-related offices

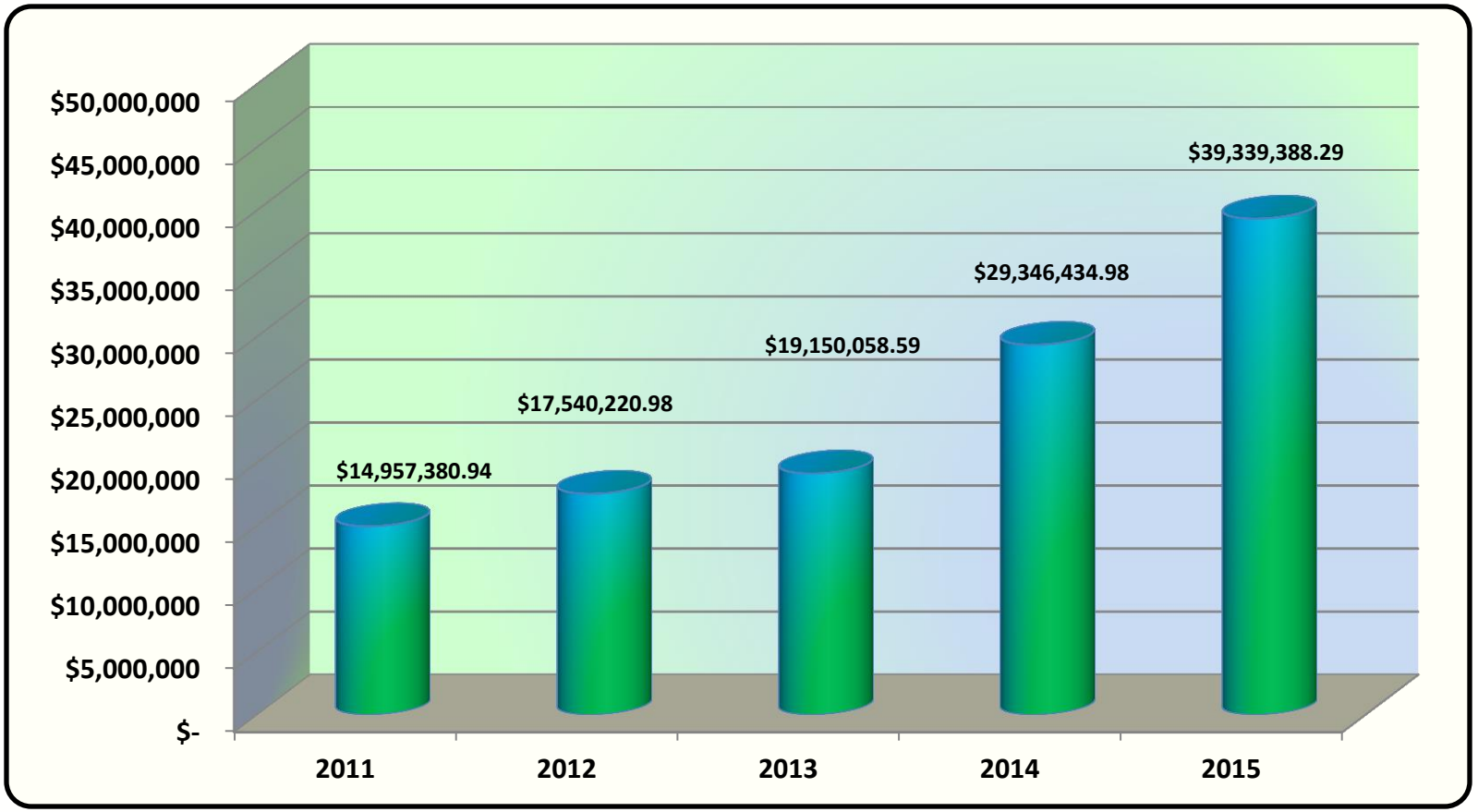
Prevention: Technical & Policy Quality:



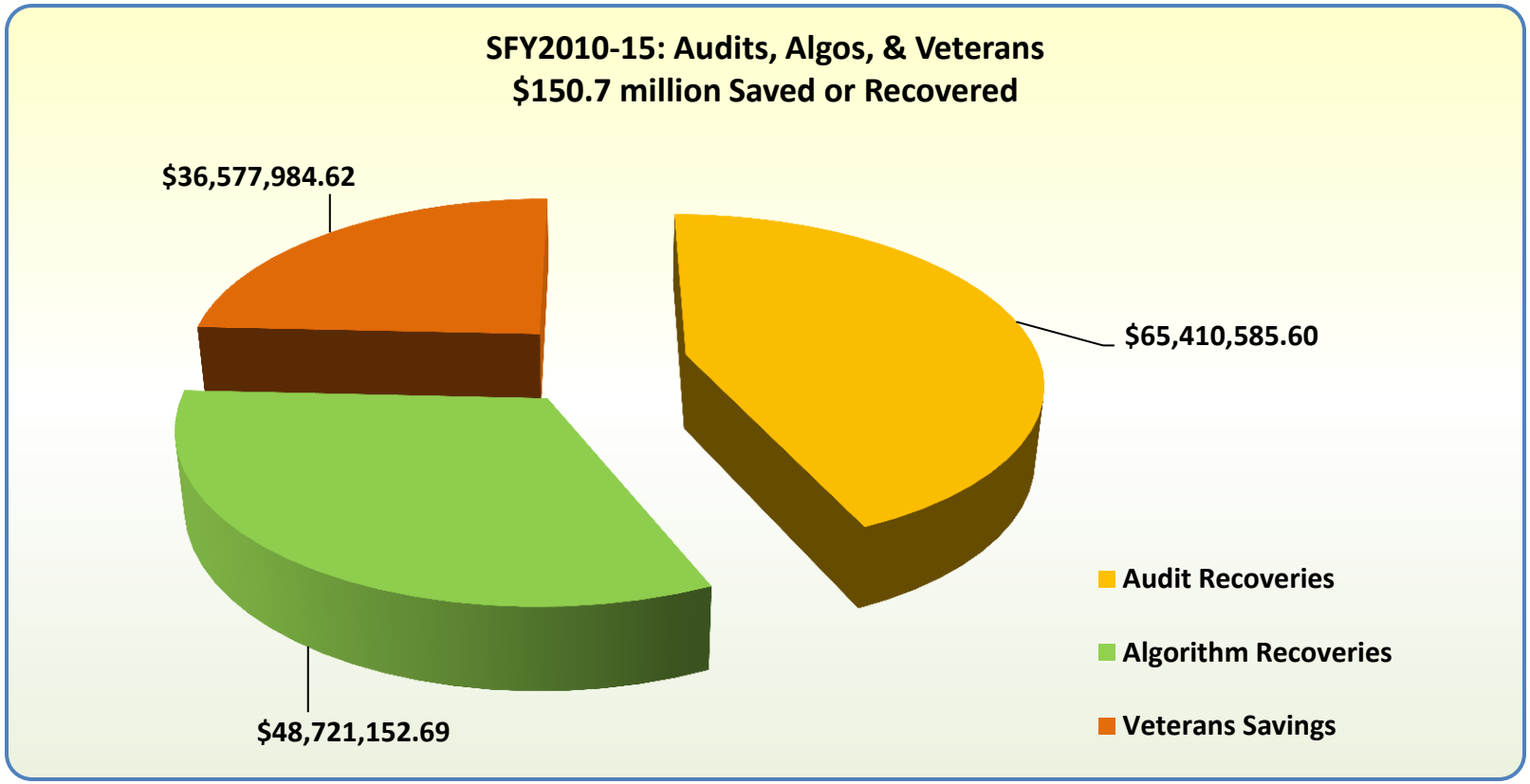
Recoveries & Savings by Month:



Recoveries & Savings by State Fiscal Year:



Total Recoveries & Savings—SFY2010-2015:



What can $150 million buy?

- **1.6 million well-child exams**
- **73,000 global maternities**
- **1.3 million Primary Care Physician visits**
- **4.4 million comprehensive oral exams**

Program Integrity Activities & Tools:

- Extrapolated Audits:
  - Statistically valid
  - Actuarially designed & approved
  - Comprehensive & Instructive

- Focused Audits:
  - Limited scope & non-extrapolated
  - An apparently abused code or code set

Program Integrity Activities & Tools:

- Self-Audit:
  - Provider-initiated: self-reporting to the State Medicaid Agency as required by 42 CFR §1320a-7K(d) & WAC 182-502A-0501
  - HCA-initiated: we identify an apparent problem, and request verification from the provider
- Credit Balance and TPL Audits:
  - Medicaid is the payer of last resort
  - Identifying hospital credit balances due to Medicare adjustments, third-party liability, other circumstances that relieve Medicaid

Program Integrity Activities & Tools:

- Medicaid Integrity Contractor (MIC):
  - Authorized by the Deficit Reduction Act of 2005
  - Under contract with CMS to audit on behalf of the states
- Recovery Audit Contractor (RAC):
  - Authorized and mandated by the ACA
  - RACs funded through contingency-fees on overpayment collections
  - Uneven levels of success across the country

Office of Program Integrity

Program Integrity Activities & Tools:

- Algorithms:
  - Data driven overpayment identifications—no auditor required
  - Pull-backs for:
    - Sealants on extracted teeth
    - Services in excess of limits
- Medicaid Fraud Control Unit:
  - AG's Office, work hand-in-glove with the HCA
  - Referring credible allegations of fraud
  - Investigation, prosecution, conviction

Program Integrity Activities & Tools

Medical Service Verifications (MSVs):

- ✓"The provider charged me for the visit"
- ✓"No, I didn't receive this service"

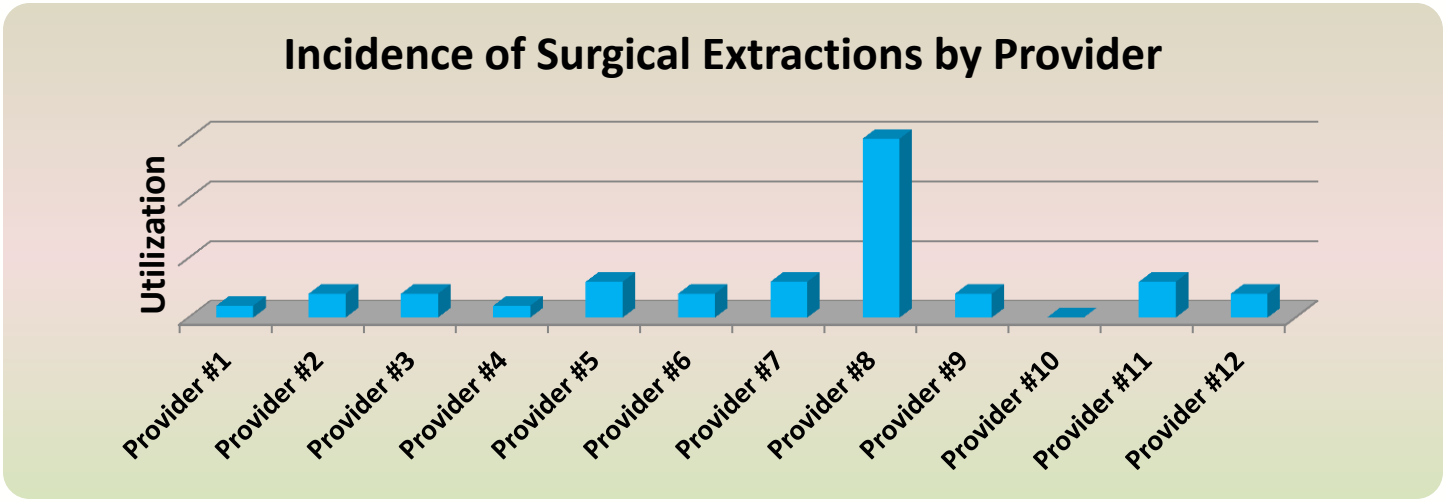
Tips, Complaints Allegations of Fraud, Waste, Abuse or Quality Concerns:

- ✓ That the facility is unclean or run down
- ✓ Dentures or prosthetics never fit correctly
- ✓ That the Office manager has instructed billers to unbundle or bill for services not provided.

Program Integrity Activities & Tools:

Data Mining:

- A dental provider ("Provider #8") bills for surgical extractions every time, because "Medicaid doesn't pay enough" otherwise.
- HCA mines data pertaining to surgical extractions across all dental providers—#8 is the one inviting more scrutiny.



Definition of Fraud and Abuse . . .

Fraud	Abuse
When someone intentionally executes or attempts to execute a scheme to obtain money or property of any health care benefit program.	When health care providers or suppliers perform actions that directly or indirectly result in unnecessary costs to any health care benefit program.

The primary difference between fraud and abuse is intention

Fraud, Waste and Abuse Basics . . .

- The fraud triangle – why individuals or organizations commit fraud

1. **Pressure**: typically comes from some financial need or desire
2. **Opportunity**: system weakness or lack of controls (historically healthcare fraud has been relatively easy)
3. **Rationalization**: the basis by which the perpetrator is able to excuse the behavior

Most Medicaid providers are honest but anyone can commit fraud

Why Medicaid attracts Fraud

The program is:

- ***HUGE***: $9-10 billion annual budget—$500 billion nationally
- ***HIGHLY COMPLICATED:***
  - 88,000 Providers
  - 19,000 procedure & diagnosis codes
  - ProviderOne processes over 2 million claims/month
- ***STRESSED*** by constant growth and change
- ***RIPE*** for endless rationalization as to why fraud is not fraud

To Be Clear . . .

The vast majority of Medicaid providers do not commit fraud

Examples of Fraud, Waste & Abuse

EXAMPLE #1: Mobile Anesthesiology

- Anesthesia is billed by time increments
- Medicaid does not pay for time in recovery
- Data indicated excessive time being billed
- Audit results: provider was billing for recovery

Rationalization: "*It would be abandonment if I didn't monitor my patients' time in recovery.*"

Subtext: "*What Medicaid pays for dictates how I practice medicine.*"

Examples of Fraud, Waste & Abuse

EXAMPLE #2: Surgery Time

- Certain surgeries billed by time increments
- Data indicate excessive surgery time
- Clinical review of medical records noted—consistently—too much time billed for surgeries.

Rationalization: "*If we billed that many units, there must have been complications.*"

Subtext: "*Whatever we bill is correct, regardless of what's in the charts.*"

Examples of Fraud, Waste & Abuse

EXAMPLE #3: School-Based Services

- Funds available to schools to offset Medicaid outreach activities and administration
- Access to funding through time-study sampling
- Allegations of stacking reimbursable activities

Rationalization: "*These funds are needed for the children and their education . . .*"

Subtext: *". . . so how could it be wrong."*

Examples of Fraud, Waste & Abuse

EXAMPLE #4: Blatant DME Fraud

PACESETTERS:

- Auditors noted white-out on prescriptions
- Investigation included data mining and interviews with physicians and facility staff
- A case of a jilted DME provider, who continued to bill Medicare and Medicaid when clients left him
- Charged, fled the country, extradited, pled guilty
- Sentenced to Prison

Most common audit findings . . .

Common audit findings

1. ***Unbundling of Procedures:*** Billing a global procedure as multiple component parts, resulting in additional revenue

2. ***Upcoding:*** Billing a higher cost procedure than the one that was performed. Example: Chart indicates no complications but higher level code is billed

3. ***Exceeding Program Limits: Examples:*** Billing more oral evaluations than allowable in a year; Billing more than 1 denture rebase in a 3-year period

4. ***Uncovered Services:*** Service not covered but billed using covered service code. Example: Lab denture reline billed, chairside reline performed.

Most common audit findings . . .

5. *Insufficient Documentation:*

- There is no documentation of the procedure
- Nothing in the chart supports the specific service, the level of service, and/or the necessity of the service

This is the most common of all findings during audits.
Think like an auditor and always remember:
"IF IT IS NOT DOCUMENTED, IT DID NOT HAPPEN"

Other common audit findings

Common audit findings

- Lack of Orders
- Chargemaster errors
- Overlapping room charges (ED, observation, inpatient)
- Outpatient services billed as inpatient
- Higher level of care is billed but not supported
- Incorrect DRG assignments
- Diagnosis unsupported by documentation

The Appeal Process

- Guaranteed by the Administrative Procedures Act
- See Chapter **34.05 RCW**, and also **41.05A.170**
- Codified in the Administrative Hearing Rules for Medical Services Programs, Chapter **182-526 WAC**

- Providers subject to any audit overpayment have appeal rights, which will be fully stipulated in audit or overpayment correspondence
- By law, providers cannot be denied due process

How a practice can prepare for audits . . .

Things providers should do:

- Maintain accurate documentation – keep records organized and available
- Don't create or alter documentation after the fact
- Develop/maintain a compliance program
- Perform periodic retrospective self audits
- Keep provider enrollment information current
- Stay current on relevant billing instructions and track changes

Preparing for Audits. . .

What can you do to prepare for audits?

- Know what kinds of records are needed, and for how long
- Chart Reviews: Proper documentation is critical – overpayments are often the result of . . .
  - ✓ Services unsupported by records
  - ✓ Documentation does not support the level of care billed
  - ✓ Illegible records/notes
- Incorrect coding: Documentation must support the code billed
- Supporting documents: provider agreements, supporting tests, required pre-authorizations

Preparing for an audit

Core elements of a compliance plan . . .

A internal program to ensure compliance with coding and billing regulations and prevent fraud and abuse:

- Conducting ongoing internal monitoring and auditing
- Implementing compliance and written practice standards
- Designating a compliance officer or primary contact
- Conducting appropriate training/education
- Responding appropriately to detected violations and developing corrective action
- Enforcing standards through well publicized guidelines

Program Integrity Topics. . .

Identification of fraud, waste and abuse means adapting to a changing landscape:

- Centers for Medicare and Medicaid Services (CMS) proposed rules expand Program Integrity in Medicaid managed care
- Advanced data analytics and technology tools bring new opportunities to Medicaid PI data mining
- Shared data systems expands Medicaid opportunities for fraud, waste and abuse
- Medicaid expansion increased the need to monitor client healthcare fraud
- Increased focus on provider credentialing and screening at the time of enrollment

Program Integrity Topics. . .

Program Integrity in Managed Care

- Premiums paid to MCOs for plan enrollees after their death
- Premiums paid for plan enrollees who live in other states
- Fee-for-Service payments to plan network providers who billed HCA for services covered by their MCO

***NOTE*:** The MC tool chest will soon be expanding: new MC draft rules were released that expand expectations and requirements for overseeing and controlling the managed care environment.

Thank you!

- Questions?
- If you still have questions, consult with the HCA Office of Program Integrity:
  - TELEPHONE: 360-725-1257
  - EMAIL: programintegrity@hca.wa.gov
  - ONLINE: http://www.hca.wa.gov/medicaid/pi/Pages/index.asp